

APPENDIX 5A

PRIOR AUTHORIZATION REQUEST FORM (PA/RF)
PSYCHOTHERAPY

MAIL TO: E.D.S. FEDERAL CORPORATION PRIOR AUTHORIZATION UNIT 6406 BRIDGE ROAD SUITE 88 MADISON, WI 53784-0088				PRIOR AUTHORIZATION REQUEST FORM <div style="border: 1px solid black; padding: 2px; display: inline-block;">PA/RF</div> (DO NOT WRITE IN THIS SPACE) ICN # A.T. # P.A. # 1234567				1 PROCESSING TYPE <div style="border: 1px solid black; padding: 10px; width: 80px; margin: 0 auto;">126</div>						
2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER 1234567890						4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE) 609 Willow Anytown, WI 55555								
3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL) Recipient, Im A.						8 BILLING PROVIDER TELEPHONE NUMBER (XXX) XXX-XXXX								
5 DATE OF BIRTH MM/DD/YY				6 SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>		9 BILLING PROVIDER NO. 43218700								
7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE: I.M. Provider 1 W. Williams Anytown, WI 55555						10 DX: PRIMARY 296.35 Major Depressive Disorder								
						11 DX: SECONDARY 309.00 Adjustment Reaction								
						12 START DATE OF SOI: N/A			13 FIRST DATE RX: N/A					
14	PROCEDURE CODE	15	MOD	16	POS	17	TOS	18	DESCRIPTION OF SERVICE	19	QR	20	CHARGES	
	90847				3		9		Family Psychotherapy		6		XXX.XX	
	90844				3		9		Individual Psychotherapy		13		XXX.XX	
22. An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAF reimbursement will be allowed only if the service is not covered by the HMO.											TOTAL CHARGE		21	XXX.XX
23		MM/DD/YY				24		I. M. Provider, M.S.						
		DATE						REQUESTING PROVIDER SIGNATURE						

(DO NOT WRITE IN THIS SPACE)							
AUTHORIZATION:				PROCEDURE(S) AUTHORIZED		QUANTITY AUTHORIZED	
<input type="checkbox"/>	APPROVED	<div style="border: 1px solid black; width: 100px; height: 20px;"></div>		<div style="border: 1px solid black; width: 100px; height: 20px;"></div>			
		GRANT DATE		EXPIRATION DATE			
<input type="checkbox"/>	MODIFIED	REASON:					
<input type="checkbox"/>	DENIED	REASON:					
<input type="checkbox"/>	RETURN	REASON:					
DATE				CONSULTANT/ANALYST SIGNATURE			